VIRGINIA ROUTINE HORMONAL CONTRACEPTIVE SELF-SCREENING QUESTIONNAIRE

Name: _____ Today's Date: _____ Weight: _____

Date of Birth: _____ Age: _____ Healthcare Provider's Name: _____

Healthcare Provider's Telephone, Fax, or Email:_____

What was the date of your last women's health clinical visit? _____

Any Allergies to Medications? *Yes / No* If yes, list them here: _____

Pregnancy Screen:

1.	Did you have a baby less than 6 months ago, are you fully or nearly-fully breast feeding, *AND* have you had no menstrual period since the delivery?	Yes □ No□
2.	Have you had a baby in the last 4 weeks?	Yes □ No□
3.	Did you have a miscarriage or abortion in the last 7 days?	___/___/___
4.	Did your last menstrual period start within the past 7 days?	Yes □ No □
5.	Have you abstained from sexual intercourse since your last menstrual period or delivery?	Yes □ No □
6.	Have you been using a reliable contraceptive method consistently and correctly?	Yes □ No □
If you answered NO to ALL of the questions above, you may stop here and consult with the pharmacist. If you answered YES to at least one of the questions above, please proceed with completing this form.		

Additional Information:

7.	Do you think you might be pregnant now?	Yes □ No□
8.	Have you used emergency contraception within the last 5 days?	Yes □ No□
9.	What was the first day of your last menstrual period?	___/___/___
10.	Have you ever been told by a medical professional not to take hormones?	Yes □ No □
11.	Have you ever taken birth control pills, or used a birth control patch, ring, or injection?	Yes □ No □
12.	Did you ever experience a bad reaction to using hormonal birth control?	Yes □ No □
13.	- If yes, what kind of reaction occurred?	
14.	Have you previously had contraceptives prescribed to you by a pharmacist?	Yes □ No □
15.	Are you currently using any method of birth control including pills, or a birth control patch, ring or shot/injection?	Yes □ No □
16.	- If yes, which one do you use? (List here)	
17.	Do you have a preferred method of birth control that you would like to use? (check box) ☐ A pill that you take daily ☐ A patch that you change weekly ☐ A vaginal ring that you change monthly ☐ An injection that you receive every 3 months	
Medical History		
Smoking:		
18.	Do you smoke cigarettes or vape nicotine?	Yes □ No □
19.	-If yes, number or equivalent number of cigarettes per day either smoked or vaped.	_____ /day

Postpartum (nonbreastfeeding women)/Breastfeeding:

20.	Have you given birth within 21 days? If yes, how long ago?	Yes □ No □
21.	Are you currently breastfeeding?	Yes □ No □
Diabetes:		
22.	Do you have diabetes?	Yes □ No □
Headaches:		
23.	Do you get migraine headaches?	Yes □ No □

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24.	- If yes, have you ever had the kind of headaches that start with warning signs or symptoms, such as flashes of light, blind spots, or tingling in your hand or face that comes and goes completely away before the headache starts?	Yes □ No □
Hypertension, History of high blood pressure during pregnancy:		
25.	Do you have high blood pressure, hypertension, or high cholesterol? (Please indicate yes, even if it is controlled by medication)	Yes □ No □
Deep venous thrombosis (DVT)/Pulmonary embolism (PE), Ischemic heart disease, Known thrombogenic mutations, Multiple risk factors for atherosclerotic cardiovascular disease, Peripartum cardiomyopathy, Stroke, Valvular heart disease:		
26.	Have you ever had a heart attack or stroke, or been told you had any heart disease?	Yes □ No □
27.	Have you ever had a blood clot?	Yes □ No □
28.	Have you ever been told by a medical professional that you are at risk of developing a blood clot?	Yes □ No □
29.	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	Yes □ No □
History of bariatric surgery:		
30.	Have you had bariatric surgery or stomach reduction surgery?	Yes □ No □
Breast disease:		
31.	Do you have or have you ever had breast cancer?	Yes □ No □
Cirrhosis, Gallbladder disease, History of cholestasis, Liver tumors, Viral hepatitis:		
32.	Do you have or have you ever had hepatitis, liver disease, liver cancer, or gall bladder disease, or do you have jaundice (yellow skin or eyes)?	Yes □ No □
Rheumatoid arthritis, Systemic lupus erythematosus:		
33.	Do you have lupus, rheumatoid arthritis, or any blood disorders?	Yes □ No □
Epilepsy, HIV, Tuberculosis, Drug Interactions (Antiretrovirals, Anticonvulsant, Antimicrobial therapy):		
34.	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?	Yes □ No □
35.	- If yes, list them here:	
Other information:		
36.	Do you have any other medical problems or take any medications, including herbs or supplements?	Yes □ No □
37.	- If yes, list them here:	
38.	Will you be immobile for a long period? (e.g., flying on a long airplane trip, etc.)	Yes □ No □

Internal use only

☐ Verified DOB with valid photo ID BP Reading _____/_____

☐ Drug Prescribed:_____

Sig:_____

Pharmacist Name:_____

Pharmacy Name and Address:_____

Pharmacy Phone:_____

☐Patient Referred

Reason(s):_____

Notes:_____

_____

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